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TEAMSTERS LOCAL 2000
Flight Attendant Union

National Safety & Health Department

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September 20, 2000

U.S. Department of Transportation Dockets
Docket No. FAA-2000-7119 - 392
400 Seventh Street, SW
Room Plaza 401
Washington, DC 20590

RE: NPRM (Notice No. 00-03), Emergency Medical Equipment

Dear Madam/Sir:

This is in response to subject Notice of Proposed Rulemaking relative to the FAA proposal to amend 14 CFR Part 121 by adding subpart X and amending appendix A and related sections.

On behalf of Teamsters Local Union 2000, representing over 11,000 Northwest Airlines Flight Attendants, this is to present comments and recommendations with respect to modification of subject regulations pertinent to provisions designed to provide the option of treatment of serious medical events occurring inflight.

As passenger enplanement statistics indicate, an increase in passengers needing inflight medical assistance is anticipated for the future. Further, the overall aging of the general population - worldwide - is expected to result in a greater number of air carrier passengers with medical conditions and subsequently passengers who are more likely to experience an inflight medical event.

The increased occurrence of such incidents brings a greater degree of response and illness/injury management and support responsibilities to all Flight Attendants irrespective of air carrier affiliation, type/model aircraft operated or route flown. When medical emergencies occur, compliance with certain Federal Aviation Regulations pertinent to cabin crewmembers may become more challenging. For example, if a medical emergency occurs during takeoff/landing and treatment of a passenger must continue through those phases of flight (such as with administration of CPR), how are the applicable rules interpreted? In this case, Flight Attendants are required to be properly restrained in assigned jumpseats. These types of circumstances must be addressed and interpretation made.

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Additionally, the increased occurrence of medically-related incidents requires a clearer definition of the "scope of duty" of a Flight Attendant. As is known, Flight Attendants are not licensed medical professionals and, therefore, cannot determine when to cease CPR, when to officially declare death, when quarantine may be required, etc.

In the same light, the legal immunity (hold harmless protection) afforded Flight Attendants in the use of automated external defibrillators (AED) and associated medical support equipment presents a concern. As written, the Aviation Medical Assistance Act of 1998 includes a "Good Samaritan" provision to protect from legal liability those individuals who assist in a medical emergency, including a passenger, pilot or Flight Attendant. The provision also provides protection to the air carriers from liability for the negligence of a passenger who volunteers to help in a medical emergency - but only if: (1) the passenger is not an employee of the air carrier and (2) the air carrier in good faith believed that the passenger was qualified to provide that help.

Such legal protection specifically afforded Flight Attendants must be clearly defined and made a part of proposed regulations applicable to crewmember actions in support of a medical emergency - whether on or off the aircraft (rendering assistance in a jetway, for example).

There is an increasing awareness among companies (air carriers included) that they could be liable if someone goes into cardiac arrest on their premises and they are not prepared to assist. A "standard of care" to respond is an increasing expectation by the general public. Previous to certain air carriers voluntarily installing AEDs on their aircraft, the standard policy for handling sudden cardiac arrest, i.e. apply CPR and diverting the flight to obtain emergency care on the ground, is wholly inadequate, particularly in light of the availability of technological advancements made to support these types of medical emergencies.

Consumers, medical associations, and many emergency care and other physicians have criticized the airlines - and the Federal Aviation Administration in particular, for failing to update their resources and for not providing AEDs specifically to treat sudden cardiac arrest, a life-threatening emergency under any circumstances. In this case, timing is everything, as the chance of survival drops by about 10% with each passing minute. Unless defibrillation occurs within the first 10 minutes, it is not likely to be successful.

A question remains, however, does raising the bar raise unrealistic expectations by the flying public with respect to medical care that can be delivered inflight? The presence of AEDs and a variety of medications does not necessarily ensure a better outcome. No matter how well-equipped air carriers become, they are still transportation vehicles and caution must be used to not represent an airplane as if it were a well-equipped emergency room on the ground.

Onboard medical assistance will continue to be discretionary, as well as limited, and must be regarded as interim emergency treatment with no unrealistic expectations of favorable outcomes for passengers experiencing medical events inflight, particularly those that are life-threatening. Further, it is agreed that it is unrealistic to expect crewmembers to achieve the same level of proficiency as emergency medical personnel and highly trained physicians who perform medical procedures routinely.

With that said, it is recognized that Flight Attendants have - and will continue to be - the key to passenger' safety and survivability - whether it involves non-routine occurrences inflight or on the ground. As a profession, we take ever-increasing responsibilities seriously and duty to passengers of the highest priority.

To the extent the flying public and/or individual air carriers perceive Flight Attendants in a "first responder" role, Flight Attendants must have both the training and personal protection to take on those responsibilities. Further, when a carrier places its Flight Attendant workforce in a "first responder" role, then it would be expected that minimum training and re-qualification standards have been met. It is the responsibility of the Federal government to set such standards consistent with the experience of the traditional accrediting organizations such as the American Heart Association and the American Red Cross.

The training provided must be at least as comprehensive as that provided to other "first responders", such as police and firefighters, whose primary responsibilities do not include emergency medical care.

Four essential skills must be included in any AED training, as follows:

1. **CPR**
2. **Relief of foreign-body airway obstruction**
3. **Use of face mask for rescue breathing**
4. **Use of the AED**

Such training must also include bloodborne pathogens, with the current OSHA Bloodborne Pathogen Standard applied to Flight Attendants to safeguard against the known risks involved. It would be irresponsible to require AED training and not include CPR and bloodborne pathogen training as well.

Standardized AED and cardiopulmonary resuscitation training tailored to operational requirements of Flight Attendants working in the aircraft cabin is necessary. With such standardization, all Flight Attendants must be trained to proficiency. Such standardized training and proficiency requirements would alleviate any explanations to passengers and/or assumptions concerning varying policies/procedures among the air carriers, particularly as it concerns frequent flyers who may travel with different carriers yet expect similar policies and proficiency of cabin crewmembers.

To the extent proposed in amended §121.805, the requirements relative to all crewmembers (flight deck and cabin) to be instructed in the location, function and operation of emergency medical equipment to include modified Emergency Medical Kits and AEDs is strongly supported. When any emergency occurs, full crew coordination/communication and support is mandatory to ensure the situation is managed to the best interests of all concerned. As is practiced, in-flight procedures include flight deck notifications when non-routine events occur in the cabin.

The more knowledgeable all crewmembers are with respect to emergency medical equipment onboard the better equipped crews are to make judicious decisions. It is irresponsible to expect such decisions to be made especially when they involve matters of life and death, without an understanding and familiarization of emergency medical equipment located in the cabin and the procedural aspects involved therewith.

The undeniable value of coordinated crew actions has been well documented with respect to incidents/accidents and, in this case, the same protocols must apply.

Relative to the enhancements proposed to current Emergency Medical Kits, the additional medications have been shown to be useful to medical personnel who may treat a stricken passenger, particularly those who undergo heart-related trauma (with or without the use of an AED). As stated, the proposed enhancements are justified and support best medical practice.

One aspect of the Emergency Medical Kits (EMK) not addressed in the proposed rule change involves the quality of the contents of the EMKs. As has been noted and commented to by medical professionals, in many cases, the contents include cheap, disassembled parts, with medical equipment manufacturers taking advantage of the air carriers by placing sub-standard equipment in the kits purchased by the carriers. The applicable regulations specify contents of the EMK but do not make determinations about their quality.

As referenced in FAA report published in 1991, and based on a two-year study of medical kit use, the poor technical quality of the most frequently used equipment was revealed. This aspect of EMKs must be addressed. What good are the contents - enhanced or otherwise - if they cannot be effectively used in a potential life or death situation?

As has been discussed above, the expertise of professional medical personnel and physicians onboard will continue to play an invaluable role in supporting and managing inflight medical emergencies.

The growing trend in the industry to utilize air-to-ground links to obtain necessary guidance and expertise in the handling of critical medical emergencies inflight serves the best interests of all concerned and should be encouraged by the Agency. Undoubtedly, passengers receive better attention inflight and Flight Attendants - with the help of medical professionals via the air-to-ground links - are better able to discriminate between life-threatening emergencies and less serious ones, which results in fewer inflight diversions. This type of medical resource is especially critical when no physician or trained medical personnel are onboard to assist.

In conclusion, in 1986, the Agency valued a hypothetical human life at only $650,000. Now that the Agency's valuation has risen to well over $2.7 million, saving just three lives a year would justify the installation of AEDs and enhanced medical kits on all aircraft in the U.S. commercial fleet. The resulting reduction in emergency medical landings (diversions), impossible to fully estimate, would further offset the costs.

The time has come to directly address the increase in passengers needing inflight medical assistance and the continuing growth of passengers flying with medical conditions who are more likely to experience an inflight medical event. From a realistic viewpoint, the proposed rule changes are long overdue. In fact, the 36-month compliance date noted for the affected rules is in question, in that many U.S. air carriers have addressed many of the provisions made part of subject NPRM, i.e. installation of AEDs and expanded medical kits.

As discussed above, our concerns include:

- Scope of duty and "first responder" equivalency training requirements
- Legal liability provisions in the use of AEDs and related emergency medical equipment applicable to crewmembers
- Comprehensive first aid training requirements, increased programmed hours of instruction/frequency for CPR, and proficiency requirements
- Bloodborne pathogen training requirements (compliance with OSHA Bloodborne Pathogen Standard) and personal protection provisions for Flight Attendants

These concerns and the impact on Flight Attendants now charged with even greater medical responsibilities must be addressed and made a part of the final rulemaking.

As stated, Teamsters Local Union 2000 fully supports the action the Agency has taken with respect to the enhancement of Emergency Medical Kits and carriage of Automated External Defibrillators on transport aircraft. However, we urge the Agency to address the concerns expressed above in the final rule.

Let us work together to meet the goal of reducing pain and suffering of passengers involved in medical emergencies inflight in the most rational, expeditious manner. This can best be accomplished by not only providing the equipment to extend such care but the adequate training and indemnification relative to the all-important duties performed each and every day by this nation's Flight Attendants.

We look forward to the Agency taking advantage of the opportunity presented by subject NPRM to include the necessary provisions discussed herein, particularly those that affect Flight Attendants directly, and resolve the regulatory conflicts cited.

Thank you for the opportunity to express our concerns and comments relative to this timely action.

Sincerely,

TEAMSTERS LOCAL UNION No. 2000

Jeanne M. Elliott

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Director - Regulatory and Legislative Affairs
National Safety and Health Department

JME/JEV

cc: The Honorable Jane Garvey
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